BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

In the Matter of the Emergency Medical Technician-Paramedic License of:

PETER M. TAGLIERE, Respondent

License No. P20123

Agency Case No. 15-0216

OAH No. 2016080897.1

PROPOSED DECISION ON REMAND

Irina Tentser, Administrative Law Judge (ALJ) of the Office of Administrative Hearings (OAH), State of California, heard this matter on December 8, 2016 at Los Angeles, California.

Stephen J. Egan, Senior Staff Counsel, represented Sean Trask (Complainant).

Dana S. Martinez, Attorney, represented Peter M. Tagliere (Respondent), who was present throughout hearing.

Oral and documentary evidence was received. The record was left open for the parties to submit written closing briefs no later than December 16, 2016. On December 16, 2016, Respondent filed and served his closing brief, marked as Exhibit H. On

December 19, 2016, Complainant filed its Closing Brief, marked as Exhibit 19. Both briefs were considered.

The matter was submitted for decision on December 19, 2016.

In reviewing the record and preparing the Proposed Decision for this case, the ALJ found that Exhibit 7, pages 114 to 117, and Exhibit 16, pages 142 to 144, contained medical information/records of a witness. Accordingly, based on the good cause described above, the ALJ, reopened the record on December 22, 2016, and provided notice to the parties in accordance with California Code of Regulations, title 1, (Regulations) section 1022 of the motion and made the motion to issue a protective order and place Exhibit 7, pages 114 to 117, and Exhibit 16, pages 142 and 144, under seal pursuant to Regulations, section 1030.

Remand Order

The Proposed Decision was issued on February 8, 2017, recommending dismissal of the Accusation. Emergency Medical Services Authority's (EMSA) then-Director, Howard Backer MD, MPH, FACEP (Director), did not adopt the ALJ's Proposed Decision. On June 29, 2017, the Director issued a Decision and Order revoking Respondent's paramedic license.

On August 24, 2017, Respondent filed a verified petition for writ of mandate challenging the EMSA's decision. On April 17, 2019, in the matter of ***Peter M. Tagliere v. Director of the Emergency Medical Services Authority of the State of California***, Los Angeles Superior Court (LASC), Case No. BS170701, Judge Mary H. Stobel issued a peremptory writ of mandamus directing EMSA's Director to: 1) set aside its final administrative order in the Office of Administrative Hearing number 2016080897 and

2) pursuant to Code of Civil Procedure section 1094.5, subdivision (f), reconsider this case in light of the LASC's opinion and judgment in Case No. BS170701.

On May 9, 2019, EMSA's Director issued an Amended Decision and Order Pursuant to April 17, 2019 Judgment and Writ of Mandamus in OAH Case No. 2016080897 by which the Director complied with the Superior Court Judgment and Writ of Mandamus by 1) setting aside the Decision and Order previously issued in the matter revoking Respondent's license; 2) reconsidering this case pursuant to Code of Civil Procedure section 1094.5, subdivision (f), in light of the Superior Court's opinion and judgment; and 3) stating he would restore Respondent's license to its probationary status pending Respondent establishing that he is current with all regular licensing requirements, including but not limited to those pertaining to fees and continuing education hours, and pending the outcome of the reconsideration of this matter.

On March 5, 2020, an Amended Request to Set pursuant to California Code of Regulations, title 1, section 1018, and Order to Remand to the Office of Administrative Hearings was filed with OAH. The Order attached the Superior Court judgment in LASC Case No. BS 170701, filed on April 17, 2019, and stated that EMSA adopted the Superior Court judgment ordering EMSA to set aside its final administrative order in OAH Case No. 2016080897. EMSA's current Director, Dave Duncan, ordered that the matter be remanded to OAH for a new hearing consistent with the LASC court judgment in Case No. BS170701.

In issuing its judgment, the LASC court found that, "[the Director's] findings about gross negligence and incompetence are not supported by the weight of the evidence without expert testimony. Under the circumstances of this case, whether [Respondent] was grossly negligent or incompetent with respect to his duties is not a

matter within lay comprehension and requires expert testimony." (Exhibit 12, LASC Judgment, p. 8.) Accordingly, the matter was remanded for hearing to take expert evidence on the issue of what is the applicable standard of care to determine gross negligence and incompetence.

Additional Hearing Day

The remand hearing in this matter was heard by the ALJ with OAH on July 8, 2021. Complainant was represented by Tara Newman, Deputy Attorney General. Dana M. Martinez, Attorney, represented Respondent.

At the remand hearing, expert witness testimony, evidence relied on by expert witnesses, and argument was provided. Additional jurisdictional documents were submitted which had previously been provided to Respondent.

By agreement of the parties, the ALJ left the record open for the parties to file written closing briefs by August 9, 2021. On July 29, 2021, the parties filed a joint stipulation requesting additional time to file closing briefs. On July 30, 2021, the ALJ granted the parties' motion and extended the deadline to file closing briefs until August 20, 2021.

On August 20, 2021, Respondent filed his closing brief, marked as Exhibit A. After the record closed on August 20, 2021, Complainant filed his closing brief untimely on August 23, 2021 based on error regarding the deadline to file the brief. The brief was marked as Exhibit 15.

The record closed on August 20, 2021. On September 15, 2021, the ALJ issued an order reopening the record ordering Complainant to file a certified copy of the transcript of the July 8, 2021 hearing. Complainant filed the certified copy of the

transcript on September 17, 2021. The record re-closed and the matter was submitted on September 21, 2021.

In reviewing the certified copy of the transcript of the July 8, 2021 hearing, the ALJ notes that Exhibits 8 and 11 were marked but were inadvertently not received into evidence. To clarify, Exhibits 8 and 11 were admitted into evidence.

FACTUAL FINDINGS

Parties and Jurisdiction

1. Complainant made the Accusation and Petition to Terminate Probation (the Accusation) in his official capacity as the Chief, Emergency Medical Services Personnel Division of the California Emergency Medical Services Authority (EMSA) of the State of California.

2. On July 22, 2003, Respondent was issued emergency medical technician-paramedic (EMT-P) license number P20123 by the EMSA. The status of the license was unclear as of the date of the remand hearing in this matter.

3. On September 22, 2014, the EMSA Authority Director adopted a Decision and Order (Decision and Order), which became effective on October 22, 2014, placing Respondent's EMT-P license on probation for three years. Respondent's license discipline was based on findings that he violated the Health and Safety Code by physically abusing a patient under his care.

4. Complainant now seeks to discipline Respondent's EMT-P license and terminate his probation based on an incident that occurred on June 26, 2015.[1]

June 26 Incident

5. On June 26, J.H.[2] (Patient), who was approximately five months pregnant, and E. L. (EL) were at a restaurant having dinner with their five children. Patient's water broke and the family left the restaurant to seek medical care for Patient. EL began driving Patient to search for the nearest hospital. At some point, Patient began to bleed.

6. As he was driving, EL called 911 seeking emergency medical care for Patient. The 911 operator directed EL to stop at the Los Angeles City Fire Station 60 (the Station) to obtain help. EL pulled up to the Station as directed.

7. At approximately the same time, Respondent arrived at the Station in a "plug buggy"[3] to report to work. Respondent exited the vehicle and approached EL.

8. EL informed Respondent that Patient was pregnant; had gone into labor; and her water had broken. Respondent did not assess Patient and provided no care to her; despite being told of the circumstances of the Patient and the request by the

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[1] All dates refer to 2015 unless otherwise indicated.

[2] Initial are used in lieu of full names to protect the individuals' privacy.

[3] A Los Angeles Fire Department (LAFD) pick-up truck.

Patient's husband for help. Instead, Respondent told EL he could continue to drive Patient to the hospital himself or that Respondent could call them an ambulance.[4]

9. Approximately 30-40 seconds after EL and Respondent began speaking, the Station's ambulance returned to the Station. Firefighter-Paramedic Christopher Beaty (Beaty) was the passenger and Firefighter-Paramedic Kasahara (Kasahara) was the driver of the ambulance.

10. Beaty was informed Patient was in labor and her water had broken. Beaty did not assess the Patient and provided no care to her, despite being told of the circumstances of the Patient and the request by EL for help.

11. Kasahara backed the ambulance into the Station. Kasahara did not assess Patient and provided no care to her.

12. Based on communication between Respondent, Beaty, and Kasahara, a "still alarm"[5] related to Patient was generated to begin LAFD treatment. However,

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[4] Complainant did not establish through clear and convincing evidence that Respondent stated "We don't deliver babies here" in response to EL's request for assistance and/or that Respondent was aware Patient was bleeding. (Exh. 1 at p. AR007.) Respondent denied making the statements and being told that Patient was bleeding. EL and Patient testified they could not recall their exchange with Respondent in detail. Therefore, considering Respondent's denial, there is insufficient evidence to sustain the allegations.

[5] According to Respondent, a "still alarm" is an alarm that originates at the fire station level based on something that happens outside of the dispatch system.

neither Respondent nor Beaty communicated to EL and Patient that LAFD intended to care for Patient. Instead, Respondent walked away from EL to retrieve equipment from his plug-buggy and Beaty went to the ambulance to get an ePCR (Electronic Patient Care Reporting) to document the incident.

13. As Beaty was walking back to EL's vehicle after retrieving the ePCR from the ambulance, he saw the vehicle leave and heard EL yell as he drove off something to the effect of, "I can't believe that you're not going to help my wife."

14. As a result of EL's and Patient's reasonable belief, based on the totality of the exchange between them and Respondent, that LAFD was not going to provide care for Patient and her urgent need for medical care, EL left the Station and drove Patient to the hospital himself.

Expert Evidence

DR. STRATTON'S EXPERT TESTIMONY

15. In support of the claims that Respondent was grossly negligence and incompetent in his actions towards Patient and thereby violated the terms of his probation, Complainant presented the expert testimony of Dr. Samuel J. Stratton.

16. Dr. Stratton obtained a Bachelor of Science degree in chemistry and medical degree at New Mexico State University. He trained and did residence at the University of California, Irvine (UCI), and subsequently obtained a Master of Public Health at UCI. In addition, Dr. Stratton obtained a certification in field epidemiology from the University of North Carolina.

17. Dr. Stratton is a senior program analyst for the Orange County Emergency Medical Services (EMS) agency in Orange County, California, and a

professor in the School of Public Health at the University of California, Los Angeles (UCLA). As EMS's senior program analyst, Dr. Stratton's duties include reviewing policy and overseeing staff statistics and the legal and development of policies for the medical director to review and approve.

18. At UCLA, Dr. Stratton teaches courses in emergency public health; primarily disasters or mass casualty incidents, and how they relate to public health issues, like COVID-19. Dr. Stratton also teaches courses and performs research in US-Mexico border health.

19. From December 2006 through January 2019, Dr. Stratton was the Deputy Health Officer Medical Director, EMS, Health Disaster Management, Orange County, California. In that position, his primary EMS duties included overseeing the medical aspects, including policy development, education, certification of all EMS personnel, county accreditation of paramedics, certification of emergency medical technicians, and development of EMS systems.

20. From 1993 to 2003, Dr. Stratton served as the Medical Director for Los Angeles County EMSA, where his duties were the medical oversight of the entire EMS systems. From July 1988 through March 1993, Dr. Stratton was the medical director for the Paramedic Training Institute, Los Angeles County, EMSA. His duties in that position were to develop educational programs, educate paramedics, help with developing educational policies and procedures, and provide continuing education for both paramedics and Emergency Medical Technicians (EMTs).

21. Dr. Stratton was retained by Complainant to render an expert opinion at hearing. In forming his opinion, Dr. Stratton reviewed the entire administrative record, pages 1 through 553. In addition, Dr. Stratton reviewed the audio CD and partial

transcript of the 911 call on AR-47 and AR-48, which he found to be consistent (Exhibits 1 and 9.)[6]

22. Dr. Stratton explained that the standard of care for an EMT-P, such as Respondent, in dealing with an emergency patient, such as Patient, is first to establish scene safety and then to fulfill his duty to treat Patient by assessing her. Regardless of the somewhat unusual situation, Respondent was on duty when Patient and her husband drove up to the Station. He was in uniform and on a fire property. He was in a clearly marked Los Angeles City fire plug buggy. He had lights and sirens and a radio. He was being paid by taxpayer money.

23. In such a situation, Dr. Stratton opined the first thing paramedics, like Respondent, are taught is that they have a duty to treat. They cannot refuse to treat someone in that circumstance because the public's expectation is that the EMT-P will treat, and that is what EMT-Ps are paid to do. Dr. Stratton noted that Respondent admitted in multiple testimonies that he never looked at Patient, who was sitting within feet of him in labor. Instead, Respondent focused on the husband, EL, and not Patient. The Patient was awake, alert, and communicating, and based on her testimony, as reviewed by Dr. Stratton, understood some of the conversation that was going on around her.

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[6] The transcript of the 911 call was previously admitted at the first hearing of this matter. (Exhibit 1.) The audio CD 911 call was admitted as administrative hearsay at the remand hearing day. (Exhibit 9.) Based on comparison of the transcript and audio, it is found that the audio accurately reflects the transcript portions previously admitted as direct evidence.

24. Dr. Stratton opined that the moment EL stated to Respondent that he had an emergency in California, EMSA regulations define the situation as a medical emergency. Accordingly, once there is an established emergency, Respondent on scene has a duty to treat. And yet, after establishing scene safety, Respondent never looked at Patient, never asked her how she was, and failed to get the initial parts of the assessment. Respondent never looked at Patient's lips or her skin to see if she may be hemorrhaging or going into shock. Respondent never assessed her mental status, another sign of shock, if one is becoming confused. Respondent never checked to make sure Patient's airways were open; all the basic things an EMT-P does not need equipment to do, and which even an EMT is expected to do in California, much less a paramedic level 3, such as Respondent, an experienced paramedic.

25. Once the assessment is done, Respondent had a duty to go to the next step, which, in this case, would be to get an ambulance. Dr. Stratton noted that Respondent had a radio in the truck, and never checked the Station by ringing the doorbell to ascertain if the Station had personnel in it, merely looking at the Station to check for personnel. Respondent did not try to get extra help, instead told EL to take Patient to the hospital himself and continued to tell EL to take Patient to the hospital himself after an ambulance arrived at the Station.

26. In the alternative, Respondent could have arranged transport in the ambulance that arrived at the Station or used his radio before the ambulance arrived to dispatch for another ambulance, backfilling from another station in the area.

27. Dr. Stratton testified that one of the reasons an EMS system has existed in the United States for over 100 years is to transport sick and injured people through heavy traffic safely in an ambulance marked with lights and sirens if you need them to prevent individuals in emergency situations from running lights, like EL said he had to

do to get to the Station. Dr. Stratton opined that it's a violation of local medical control policy, reference 808, to fail to transport a patient under the circumstances. Reference 808 states, in sum, that a patient with abdominal pain and vaginal bleeding must be transported. They cannot be refused transportation by EMS through ambulance transport.

28. Dr. Stratton opined that failing to provide transport is below the standard of care because no matter how fast Respondent believed you can drive a private vehicle at six o'clock in the evening in North Hollywood, an ambulance can get to the hospital quicker. Respondent could have arranged transport by escorting EL and Patient to the hospital with his light and sirens on to the hospital. Another reason Respondent's lack of transport and actions fall below the standard of care is Respondent sent an individual he knew to be distraught, EL, whose wife is in labor, with their kids in the backseat, into traffic and into the public, thereby creating a threat to the health and safety of the community.

29. Dr. Stratton testified that when the ambulance did pull up to the Station, there is no evidence that Respondent transferred the information to the ambulance crew other than to call a still alarm. Specifically, Dr. Stratton described that Respondent did not transfer or give a patient report to the ambulance crew, which is below the standard of care. In failing to transfer care to the ambulance, Respondent still had primary responsibility for Patient.

30. According to Dr. Stratton, in Los Angeles, if you are in the situation Respondent was in, you don't drop everything and walk off to get your equipment, or turnouts. Dr. Stratton asserted that turnouts, yellow pants for firefighting, are not necessary to do the type of emergency call Respondent was involved in at the time. The proper actions culturally within the LAFD is to help your crew, the crew that's

coming in. Dr. Stratton opined that Respondent's actions in failing to help the other two paramedics who arrived to figure out what was going on with Patient was contrary to LAFD EMT-P practice.

31. Dr. Stratton opined that based on the totality of the facts Patient did not refuse treatment in this matter. Based on the defined standard of care a patient must affirmatively state that they do not want your help, to leave them alone, and that they have no medical problem. Here, it was already established that Patient had a medical problem. As noted by Dr. Stratton, Respondent referred to the wife as a patient in his testimony, he knew the Patient's husband was requesting care. As such, there was no refusal of care. In addition, Dr. Stratton described the local policy for every district in California called "against medical advice"(AMA). If someone refuses care, an EMT is to advise them of their risks and assure that they at least can tell you a plan that they have for taking care of themselves. In Respondent's situation, it would be required that Patient sign a form called an AMA form. However, Respondent did not comply with this standard of care. As a result, Dr. Stratton opined that there was no refusal of care by EL and Patient.

32. Dr. Stratton opined, in reviewing the documents in this case, Respondent acted with gross negligence as defined by Health and Safety Code section 1798.200, subdivision (c), and based on the standard of care for practice of paramedicine in California, by failing to assess Patient by visual exam and failing to even approach Patient who is in labor and in critical distress.

33. Dr. Stratton further opined that Respondent's failure to arrange transport per local EMS policy 808 was grossly negligent.

34. Dr. Stratton opined that Respondent's failure to inform the ambulance crew that arrived at the Station and to bring the ambulance crew in and provide Patient report, which is a standard practice in public practice, was grossly negligent.

35. Dr. Stratton opined that Respondent's failure to arrange transport, which is based on a California medical control policy, policy 808 from the Los Angeles County EMS Agency, applicable to this Patient who met the criteria for transport, violated the standard of care and was incompetent pursuant to Health and Safety Code section 1798.200, subdivision (c)(4).

36. In Dr. Stratton's opinion, Respondent's actions in this matter constituted a violation of the terms of his license probation based on the defined terms of the probation in the administrative record.

DAVID PIMENTLE EXPERT TESTIMONY

37. Respondent presented the expert testimony of David Pimentle to support his claims that he was not grossly negligent, incompetent, and did not violate the terms of his license probation.

38. David Pimentle has held an EMSA issued California paramedic license for the past 34 years. According to Mr. Pimentle, EMSA has never taken disciplinary actions against his license. He does not hold an EMT certificate because he is a licensed paramedic, which he asserts encompasses the practice of an EMT.

39. Mr. Pimentle's education background includes completing a high school EMT course, attending a junior college to work towards a degree in fire administration, and graduation from a paramedic school, previously called Daniel Freeman.

40. Mr. Pimentle's work history includes one year of employment as an emergency room trauma technician at Methodist Hospital of Southern California, followed by a promotion to the position of a supervisor for ancillary services.

41. Concurrently, between 1985 and 1987, Mr. Pimentle joined the Pasadena Fire Department's EMS reserve program in a nonpaid volunteer program where he performed as an EMT performing Basic Life Support (BLS) functions. As a third member of a paramedic ambulance, Mr. Pimentle also served as a primary BLS provider at large-scale events such as the Rose Bowl and the Rose Parade.

42. In 1987, Mr. Pimentle was hired by LAFD and was employed by LAFD until his retirement in approximately May 2021.

43. Since approximately 1990, Mr. Pimentle has been a member of the United Firefighters of Los Angeles City Local 112. He has served as chair of the union EMS committee and on their executive board. Mr. Pimentle served as vice chairman of the union's benefits trust and held the position on the executive board as both director and secretary. He was also the subject matter expert on the EMS negotiating team.

44. Previously, Mr. Pimentle was a member of the California Professional Firefighters for 12 to 14 years. He has attended firefighting conventions and was a member of the International Association of Firefighters, where, as he testified, he often assisted the organization's president's team on EMS issues as well as doing presentations at conventions.

45. Mr. Pimentle holds three Federal Emergency Management Agency (FEMA) certifications in the Incident Command System, the National Incident Management System, and the National Response Plan. He also has an EMS Leadership

Academy certificate from the California Fire Chiefs' Association, a 24-hour course that speaks directly to EMS issues at the state and local level.

46. Mr. Pimentle testified that he has received three letters of commendation during his career, was nominated twice for Paramedic of the Year by the Los Angeles County Department of Health Services and was a nominee for Commissioner on the California State EMS Commission under the Governor Brown administration.

47. During his tenure at LAFD, Mr. Pimentle worked as an ambulance driver, Paramedic II, and Paramedic III (lead paramedic). In 2003 he was promoted to EMS Battalion Captain and served in that position until his retirement in 2021.

48. As an EMS Battalion Captain, he oversaw two battalions, which refers to geographic locations, containing 14 fire stations, and approximately 140 paramedics and EMTs. His job duties included supervising operations as it relates to Emergency Medical Services (EMS), including responding to emergencies and, at times, observing incidences to provide quality assurance of its members' work and critique at the end of the incidences. In addition, he resupplied medications and equipment, and provided training, based on department bulletins, which included critiquing and providing members with proper instructions on how to perform better.

49. Mr. Pimentle also trained personnel, helped write department bulletins, did post-incident reviews, reviewed documentation and discussed training issues, gave on-call direction, and was a patient care advocate. According to Mr. Pimentle, in some situations where the Los Angeles Police Department (LAPD) wanted to make decisions on how to deal with a patient, he would be called to intervene when the police wanted to take a person to jail rather than going to a hospital. Based on his position as the

highest medical authority on scene of that incident, Mr. Pimentle made the final decision on what to do for patient care.

50. For approximately 16 years, Mr. Pimentle trained in EMS by helping develop LAFD or training bulletins that would address areas of recognized concern, such as patient restraints, and ensuring that every member fully understood how that policy or procedure worked. As part of providing training or assessments at LAFD, he trained members on primary and secondary assessment to be done on all patients so that the members understood the current policies and procedures.

51. Mr. Pimentle testified that he was trained in Department of Health Service policy, including reference 808, which is base hospital contacts, as well as trauma contacts. As an EMS Captain, Mr. Pimentle was involved in LAFD member investigations and was the subject matter expert for investigators regarding all issues that involve EMS, whether it is assessments or treatment and transportation policy.

52. Mr. Pimentle testified that a pregnant woman is not always considered a medical emergency if there are no other factors involved and that EMTs in California are allowed to do childbirth. However, he acknowledged that there are certain occasions where advanced life support measures are needed to help stabilize the patient en route to a hospital, qualifying a woman in labor as a medical emergency.

53. According to Mr. Pimentle, an LAFD paramedic would never use a plug buggy to escort a vehicle because it would be inappropriate. No basis for his conclusory testimony on this point was provided by Mr. Pimentle.

54. Mr. Pimentle testified that Respondent's situation with EL and Patient was not a normal situation and that there was no one answer on how the situation was to

be properly handled by an EMT paramedic. Despite the novelty of the situation, Mr. Pimentle opined that he would first expect Respondent to establish scene safety.

55. After scene safety was established, Mr. Pimentle opined that an assessment should be performed by asking Patient questions about the state of their health. Mr. Pimentle opined that the assessment can be done by asking family member questions if the chief complaint of Patient is obtained.

56. Once assessment is complete, Mr. Pimentle asserted treatment should be performed. In Respondent's situation, Mr. Pementle did not know what kind of treatment should be performed and acknowledged that transportation is an issue that is the responsibility of the paramedic or EMT. Finally, Mr. Pimentle opined that the situation should be documented.

57. Mr. Pimentle asserted he was unable to render an expert opinion on whether Respondent violated the standard of care because the LAFD does not provide its paramedics with training relevant to what do in a situation where, as Respondent, you are alone and confronted with a patient with no equipment and no ambulance.

58. However, he stressed that what course a paramedic or EMT chooses in such an unusual situation "depends on what's going on with this patient." (Exhibit 16, p. 101.) Mr. Pimentle opined that the paramedic or EMT's experience level and training is going to play an important role in deciding what to do with this patient.

59. Mr. Pimentle speculated that in Respondent's situation the right decision could have been to tell EL to drive Patient to the hospital without calling or waiting for an ambulance. According to Mr. Pimentle, Respondent presented EL with the only two options available, either calling an ambulance or driving their own vehicle to the hospital. However, in determining if Respondent's conduct was appropriate under the

circumstances, Mr. Pimentle testified that he would need additional information regarding Patient's condition, which Respondent never obtained.

60. Mr. Pimentle opined that after the ambulance arrived at the Station, Respondent should have gone over to the crew and explained to them what was going on with Patient; that they have a pregnant woman who was in active childbirth, but whether it was normal or not was unknown. At that point, Mr. Pimentle testified that the ambulance crew would need to continue the evaluation and would maybe need to call in a still alarm so that there is proper manpower and additional equipment if needed to respond to that call.

61. According to Mr. Pimentle, in so doing, Respondent would have thereby transferred care of Patient to the ambulance crew. Mr. Pimentle opined that Respondent's actions in proceeding to his plug buggy to get his turnout gear after he informed the ambulance paramedics what he learned and the initiating the still alarm was acceptable. However, he found Respondent's action in going to get his turnout gear odd, speculating Respondent's intention was to have all his required equipment prior to proceeding on an emergency vehicle, the ambulance.

62. Mr. Pimentle described that there is a requirement for a paramedic to tell the public what they are about to do. As such, Mr. Pimentle opined that if Respondent did not explain to EL and Patient why he was leaving their car (i.e., to get his turnout gear), that was "not the best communication" and it would have been "helpful" and "nice" to explicitly tell EL and Patient that "we'll all be back to help you." (Exhibit 16, p. 111.)

63. Mr. Pimentle further opined that while there is no specific order in performing an assessment, there are requirements for what constitutes an assessment.

Mr. Pimentle described a primary and secondary assessment. The primary assessment function is to determine whether the person is conscious and alert. The secondary assessment includes taking vital signs and a complete medical history and evaluating the events that are taking place currently with the patient signs and their symptoms.

64. To determine if a patient was conscious and alert, Mr. Pimentle opined that an EMT or paramedic could ask them a series of questions, including their name, where their location is, the date, and do they know what's going on. In the alternative, Mr. Pimentle described that the primary assessment could also be performed by observing Patient.

65. Mr. Pimentle acknowledged that an EMT cannot identify what is in the patient's best interests without assessing the patient and opined that if a patient presents with a chief complaint, it is a violation of the standard of care not to assess the patient. Mr. Pementle opined that after the ambulance arrived, it would not be appropriate for Respondent to tell Patient's husband to take her to the hospital himself until additional assessment had been done.

66. In Mr. Pimentle's opinion, in the circumstances of this case, if the medics on scene did not realize that EL did not understand what was going on, they should have better communicated their intent to transport Patient.

67. Despite acknowledging the lack of assessment of Patient, Mr. Pimentle ultimately opined that based on the short amount of time Respondent interacted with EL and Patient and the arrival of the ambulance at the Station, Respondent made the best decisions that he could based on his personal experience as a medic for 13 years, his training, and problem-solving skills and did not violate the standard of care. He

further opined that Respondent did not lack the degree of knowledge, skill, and ability that is ordinarily possessed and exercised by a licensed paramedic.

68. In forming his opinion as to Respondent's conduct in the situation, Mr. Pimentle reviewed the LAFD's Skelly packet regarding the incident. (Exhibit 1, pp. 32-AR122.) He did not review the remainder of the administrative record.

Ultimate Findings

69. It is the material from which expert opinion is fashioned and the reasoning of the expert in reaching his conclusion that is important. (***In re Marriage of Battenburg*** (1994) 28 Cal.App.4th 1338, 1345.) "'[T]he weight to be given to the opinion of an expert depends on the reasons he assigns to support that opinion.' [Citation]; [sic] its value ' " 'rests upon the material from which his opinion is fashioned and the reasoning by which he progresses from his material to his conclusion . . . .' " ' [Citation.] Such an opinion is no better than the reasons given for it [citation], . . ." (***White v. State of California*** (1971) 21 Cal.App.3d 738, 759-760; see also ***Richard v. Scott*** (1978) 79 Cal.App.3d 57, 63-64.)

70. Expert witnesses normally testify concerning the bases for their opinions, and the court may require the expert to state the bases before giving his opinion. (See Evid. Code, § 802.) Standard instructions give juries the commonsense directive that "[a]n opinion is only as good as the facts and reasons on which it is based." (BAJI 2.40.) An expert's opinion, even if uncontradicted, may be rejected if the reasons given for it are unsound. (***Kastner v. Los Angeles Metropolitan Transit Authority*** (1965) 63 Cal.2d 52, 58; ***Griffith v. County of Los Angeles*** (1968) 267 Cal.App.2d 837, 847.)

71. Expert opinion may be evaluated by examining the reasons and factual data upon which the expert's opinions are based. (***Griffith v. County of Los Angeles***

(1968) 267 Cal.App.2d 837, 847.) In weighing the expert testimony of Dr. Stratton versus Mr. Pimentle, Dr. Stratton's opinions are provided greater evidentiary weight and are more convincing than Mr. Pimentle's. Dr. Stratton based his opinion and findings on a thorough review of the administrative record. Mr. Pimentle, however, limited his review of the matter to a portion of the administrative record. Further, despite admitting that he had difficulty forming an opinion because of the unusual circumstances of Respondent's interaction with EL and Patient, and acknowledging that Respondent did not assess the Patient, Mr. Pimentle concluded that Respondent acted within the standard of care. Because the basis and premise of Mr. Pimentle's opinion is unsupported by credible evidence and does not sufficiently account for the fact that Respondent failed to assess Patient, his expert testimony is less convincing than that of Dr. Stratton.

RESPONDENT'S FAILURE TO ASSESS THE PATIENT WAS GROSSLY NEGLIGENT

72. Accordingly, Respondent's failure to assess, or even attempt to assess, Patient is gross negligence in that it violated the standard of care. He made no effort to assess Patient whom he knew to be in labor. When a patient has an emergency involving childbirth, paramedics are trained to "perform a detailed assessment of the patient" including "assess[ing] and manag[ng] fetal distress." (Regulations,§ 100155, subd. (b)(12).) Respondent acknowledged that he did not follow LAFD protocol which requires that personnel in contact with a patient conduct an assessment. (Exhibit 1, p. AR45.)

RESPONDENT'S FAILURE TO PROVIDE PATIENT TRANSPORT WAS GROSSLY NEGLIGENT AND INCOMPETENT

73. Respondent's failure to provide Patient with transportation when she was experiencing an emergency is grossly negligent and incompetent. Dr. Stratton's expert opinion established that after conducting an assessment the standard of care required Respondent to get an ambulance. Respondent did not call for an ambulance and instead told EL to take Patient to the hospital himself. Respondent's instructions to go by private vehicle to the hospital was grossly negligent.

74. Respondent further violated local medical control policy, reference 808, which required that a patient with abdominal pain and vaginal bleeding must be transported.[7] When an ambulance did arrive, Respondent failed to provide a patient report to the ambulance crew, which is a violation of the standard of care, and continued to instruct EL to drive Patient to the hospital himself.

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[7] Reference 808 states, in relevant part:

> EMT or paramedic personnel shall transport all patients meeting one or more of the following criteria:
>
> A. Abdominal pain . . . [¶] . . . [¶]
>
> C. Abnormal vaginal bleeding . . .

(Exhibit 1, pp. AR 99-100.)

RESPONDENT'S FAILURE TO COMMUNICATE WITH PATIENT WAS GROSS NEGLIGENCE

75. Even if Respondent was planning to help Patient, Respondent's failure to communicate with Patient that he was planning to help her was gross negligence. Here, Respondent told the husband to "take her to the hospital." (Exhibit 1, pp. AR048 and AR366.) Even after an ambulance arrived at the Station, Respondent did not tell EL and Patient that he was planning to provide an assessment or care and simply walked away from EL.

76. Respondent's contention that his behavior was justified because this was a unique situation where he was initially alone at the scene is unconvincing. Expert testimony established that the standard of care is to establish scene safety and then assess Patient. Here, even once the scene was clearly safe, Respondent never assessed the patient, which could have been done without a second person and without equipment by simply speaking with the Patient to determine her condition.

77. Respondent's argument that Patient refused treatment by leaving the Station is not credited. EL and Patient left after reasonably determining that Respondent was not going to provide care for Patient. The expert testimony of Dr. Stratton further established that Patient did not refuse care.

RESPONDENT VIOLATED THE TERMS OF HIS PROBATION

78. Respondent was required to obey all "state and local laws, statutes, regulations, written policies, protocols and rules governing the practice of medical care as a paramedic." (Exhibit 1, p. AR 160.) He was also precluded from engaging in "grossly negligent" or "incompetent" acts.

79. Based on Factual Findings 1 through 14 and 69 through 75, it was established through a preponderance of the evidence that Respondent violated the terms of his probation by acting with gross negligence, incompetence, and violating LAFD's written policies and protocols.

LEGAL CONCLUSIONS

Jurisdiction, Burden of Proof, and Standard of Proof

1. EMSA develops and adopts standards for EMT-P training and scope of practice. (§ 1797.172, subd. (a).) Sole responsibility over EMT-P licensure and licensure renewal is vested in the EMSA. (§ 1797.172, subd. (c).) EMSA has jurisdiction to proceed in this matter pursuant to section 1798.200, based on Factual Findings 1 and 2.

2. The standard of proof in an administrative proceeding seeking to suspend or revoke a certificate that requires substantial education, training, and testing is "clear and convincing evidence." (***Ettinger v. Bd. of Med. Quality Assurance*** (1982) 135 Cal.App.3d 853.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong to command the unhesitating assent of every reasonable mind. (***Katie V. v. Superior Court*** (2005) 130 Cal.App.4th 586, 594.) Complainant bears the burden of proof to establish through clear and convincing evidence that Respondent's license warrants discipline based on the Accusation's causes of action for gross negligence and incompetence.

3. To discipline Respondent's license based on a Petition to Terminate Probation, Complainant bears the burden of proving the allegations by a preponderance of the evidence. (***Sandarg v. Dental Bd. of Calif.*** (2010) 184 Cal.App.4th 1434, 1440-1441.) The term preponderance of the evidence means "more likely than

not" *Sandoval v. Bank of Am.* (2002) 94 Cal.App.4th 1378, 1388, or "'evidence that has more convincing force than that opposed to it.'" (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567 (quoting BAJI No. 2.60).)

Applicable Law

4. Section 1798.200 provides, in pertinent part:

> (b) The authority may . . . suspend, or revoke any EMT-P license issued under this division, or may place any EMT-P license issued under this division, or may place any EMT-P license holder on probation upon the finding by the director of the occurrence of any of the actions listed in subdivision (c) . . .
>
> (c) Any of the following actions shall be considered evidence of a threat to the public health and safety and may result in the . . . suspension, or revocation of a certificate or license issued under this division, or in the placement on probation of a certificate or license holder under this division: [¶]...[¶]
>
> (2) Gross negligence. [¶]...[¶]
>
> (4) Incompetence. [¶]...[¶]
>
> (7) Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the

regulations adopted by the authority pertaining to prehospital personnel.

5. "For the purposes of denial, placement on probation, suspension, or revocation, of a license, pursuant to Section 1798.200 of the Health and Safety Code, or imposing an administrative fine pursuant to Section 1798.210 of the Health and Safety Code, a crime or act shall be substantially related to the qualifications, functions and/or duties of a person holding a paramedic license under Division 2.5 of the Health and Safety Code. A crime or act shall be considered to be substantially related to the qualifications, functions, or duties of a paramedic if to a substantial degree it evidences present or potential unfitness of a paramedic to perform the functions authorized by her/his license in a manner consistent with the public health and safety." (Regulations, § 100175, subd. (a).)

6. The Decision and Order placing Respondent on probation requires him "to obey all federal state and local laws, statutes, regulations, written policies, protocols and rules governing the practice of medical care as a paramedic. Respondent shall not engage in any conduct that is grounds for disciplinary action pursuant to Section 1798.200." (Exhibit 1 at p. AR160.) Violation of probation by Respondent authorizes EMSA "to initiate action to terminate probation and proceed with actual license suspension/revocation." (*Id.* at p. AR161.)

Determination of Issues

7. Cause exists to suspend or revoke Respondent's EMT-P license pursuant to section 1798.200, subdivisions (c)(2), (c)(4), or (c)(7) because Complainant established through clear and convincing evidence that Respondent was grossly

negligent, incompetent, and violated law enforced by the EMSA in relation to Patient on June 26, as described in Factual findings 1 through 36 and 69 through 77.

8. Cause exists to impose the stayed discipline and revoke Respondent's license because Complainant established through a preponderance of the evidence Respondent violated the terms of his probation, as described in Factual Findings 1 through 36 and 69 through 78.

9. Regulations, section 100176, subdivision (a, provides the rehabilitation criteria to be considered in evaluating the placement on probation, suspension, or denial of a license. The criteria include: (1) the nature and severity of the acts or crimes; (2) evidence of any wrongful acts committed subsequent to the acts or crimes under consideration as grounds for placement on probation, suspension, or revocation; (3) the time that has elapsed since commission of the acts or crimes referred to in (1) or (2), above; (4) the extent to which respondent has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed; (5) if applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code; and (6) evidence, if any, of rehabilitation submitted by respondent.

10. All matters in mitigation and rehabilitation have been considered. Based on the totality of the circumstances and lack of rehabilitation, public protection warrants the revocation of Respondent's probationary license.

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ORDER

Emergency Medical Technician-Paramedic license number P20123 issued to respondent Peter M. Tagliere is revoked.

DATE: 10/21/2021

Irina Tentser

IRINA TENTSER

Administrative Law Judge

Office of Administrative Hearings

BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

In the Matter of the Emergency Medical Technician- Paramedic License Held by:	Enforcement Matter No. 15-0216 OAH No. 2016080897.1
PETER M. TAGLIERE, License No. P20213 Respondent.	**DECISION AND ORDER**

The attached Proposed Decision and Order dated October 21, 2021, is hereby adopted by the Emergency Medical Services Authority as its Decision in this matter. The Decision shall become effective on December 1, 2021.

It is so ordered.

DATED: October 25, 2021

Dave Duncan, MD,
Director
Emergency Medical Services Authority